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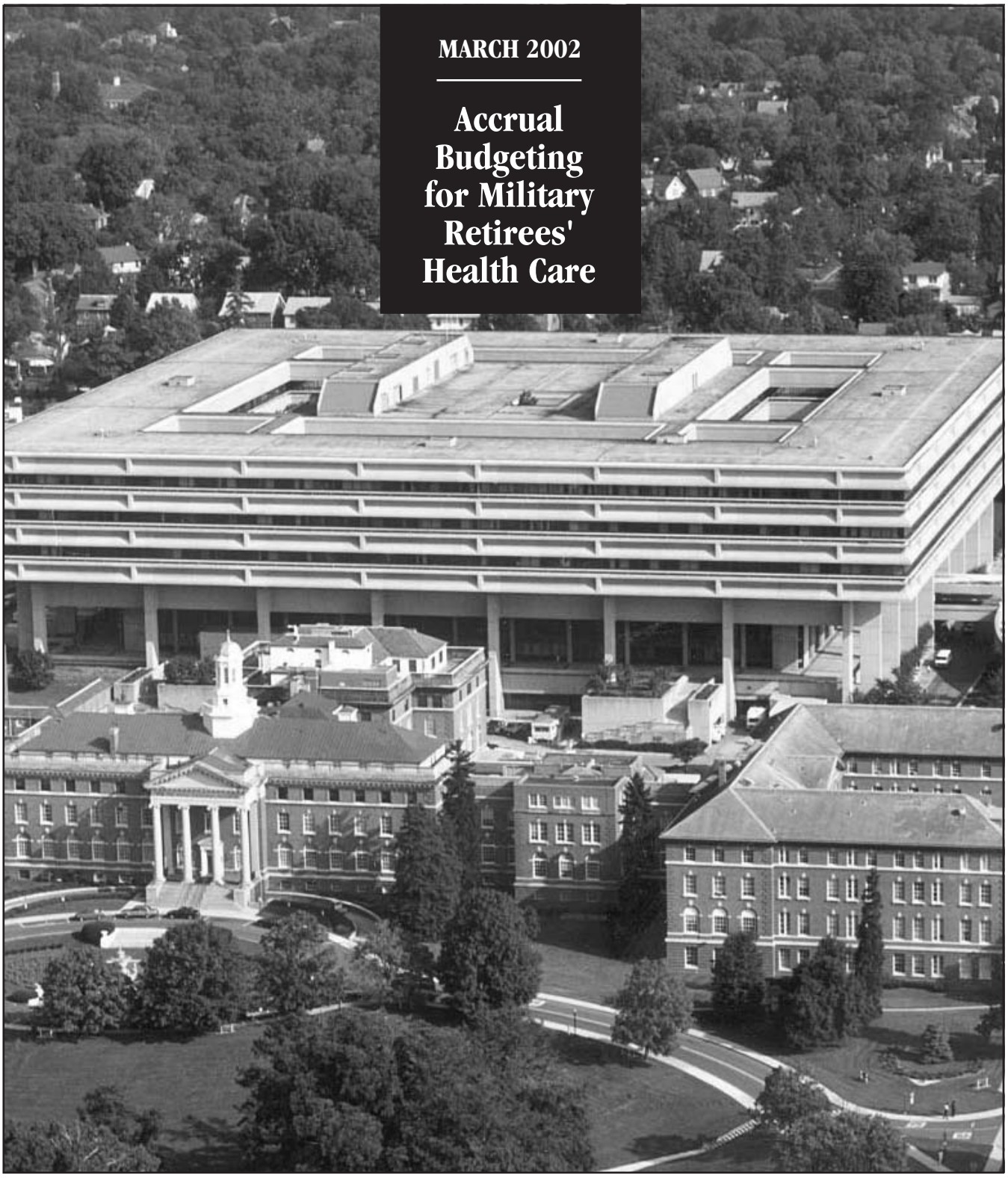
Accrual Budgeting for Military Retirees' Health Care



Accrual Budgeting

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NOTES

All years referred to in this paper are fiscal years.

Cover photo of Walter Reed Army Medical Center in Washington, D.C., appears courtesy of that organization.

PREFACE

By recognizing the costs of deferred compensation (such as pensions) in the years during which employees are working, rather than when the benefits are actually paid, accrual budgeting can provide decisionmakers with better information about the full costs of labor and better incentives to use labor cost-effectively. Therefore, accrual budgeting is becoming increasingly important in the federal budget. That method of budgeting for the health care costs of military retirees over age 65 will start in 2003, and the Administration has proposed extending it to fund younger military retirees' health care and civil service retirement benefits.

This paper, prepared at the request of the House Budget Committee, considers options for implementing accrual budgeting for military retirees' health care. The analysis examines potential changes to the currently planned accrual system, including using different accrual rates for various categories of personnel, requiring DoD's budget to bear the actuarial gains and losses of policy or legislative changes, charging the military personnel accounts (rather than the Defense Health Care Program) for the benefits, extending accrual budgeting to the care provided in the Department of Defense's (DoD's) facilities, and extending accrual budgeting to military retirees under age 65.

Russell Beland of CBO's National Security Division prepared the report under the supervision of J. Michael Gilmore. The report benefited from comments by Deborah Clay-Mendez, Sarah Jennings, Greg Kiley, Sam Papenfuss, Marvin Phaup, Rachel Schmidt, and William Trimble. The author gratefully acknowledges the cooperation of the staff of DoD's Office of the Actuary and Office of the Assistant Secretary of Defense (Health Affairs).

John Skeen edited the manuscript, Christine Bogusz proofread it, and Cindy Cleveland prepared it for publication. Kathryn Winstead produced the cover. Lenny Skutnik produced the printed copies, and Annette Kalicki prepared the electronic versions for CBO's Web site (www.cbo.gov).

Dan L. Crippen
Director

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INTRODUCTION AND SUMMARY

Beginning in 2003, the Department of Defense (DoD) will budget on an accrual basis to pay for medical care for beneficiaries who are eligible for Medicare.[1] In an accrual budget, costs—such as those for deferred compensation, including pensions and medical benefits for retirees—are recognized during the years in which the employees are working, not when the benefits are actually paid. Because accrual budgeting can provide decisionmakers with better information about the full cost of labor and better incentives to use labor cost-effectively, its use is becoming increasingly important in the federal budget; in fact, the President's budget for 2003 includes a proposal to extend it to all military retirees' health care and to civil service retirement benefits governmentwide. But the effectiveness of accrual budgeting depends in part on how it is implemented.

This analysis describes the accrual system that the federal government plans to use for medical benefits for military retirees and examines some possible legislative modifications that could be adopted to improve the accrual system before it takes effect in 2003. Three of the potential changes would affect the way that DoD makes accrual payments: (1) tying accrual charges for different types of personnel to the expected future cost of their health care, (2) incorporating those actuarial gains and losses that result from legislation or DoD's policy changes into DoD's budget, and (3) requiring the military departments to pay accrual charges out of their own appropriations for military personnel. Legislative changes along those lines could improve the system's ability to provide good information and incentives, although possibly at the cost of making the system more complex. The Administration has proposed legislation that would accomplish the third change as part of the Managerial Flexibility Act of 2001.[2]

Two other potential changes would extend accrual budgeting for the medical costs of military retirees. One, a change that would not require new legislation, extends it to cover care provided to Medicare-eligible retirees in DoD's facilities.[3] The other, a change that would be accomplished by the Managerial Flexibility Act, would extend it to cover health care benefits provided for military retirees who are not eligible for Medicare. Although those extensions might provide DoD decisionmakers with useful information and incentives, their effects would depend heavily on how payments out of the accrual fund were determined. For example, DoD's treatment facilities would have little incentive to control costs if the accrual fund simply reimbursed them for whatever they spent providing health care to Medicare-eligible beneficiaries. Alternatively, an accrual system could encourage cost-effective

1. 10 U.S.C. §1111 et seq.

2. Transmitted to the Congress by President Bush and introduced as S. 1612 by Senator Thompson on November 1, 2001.

3. Currently, DoD is in the process of adopting this change.

decisions about the care in DoD's treatment facilities by linking payments from the fund to some external indicator of what that care should cost, rather than to what DoD actually spent.

Each of the modifications discussed in this paper could increase the effectiveness of the planned accrual system. Yet even with these modifications, an accrual system would not by itself give DoD an incentive to shape the mix of in-house care and purchased care (care provided outside the department's facilities) for retirees on the basis of the full cost of that care to the federal government. Because DoD pays for the care that retirees receive in the department's facilities, whereas Medicare pays for most of the cost of purchased care, the department has a budgetary incentive to encourage elderly retirees to seek purchased care, even if that arrangement may not always represent the lowest cost to the government as a whole. If the new accrual system is to provide information and incentives that lead to cost-effective decisions from the perspective of the federal government as a whole, it may—over the long run—have to be modified to put in-house and purchased care on an equal footing. An analysis of that issue, however, is beyond the scope of this paper.

BACKGROUND

As part of its Tricare health program, the Department of Defense offers comprehensive health care benefits to military retirees and dependents who are not eligible for Medicare.[4] Until recently, however, retirees who were eligible for Medicare were not eligible for those comprehensive benefits. Instead, they were expected to rely on Medicare, and their benefits from DoD were limited to care in the department's facilities as space permitted and to certain pharmaceutical benefits.

The National Defense Authorization Act for Fiscal Year 2001 established new, more generous health care benefits for military retirees who are also eligible for Medicare. Beginning in 2002, beneficiaries became eligible for the additional benefits as DoD became the second payer to Medicare, eliminating most Medicare deductibles and copayments formerly paid by beneficiaries.[5]

In 2002, DoD will pay the cost of the new benefits—which it estimates will amount to about $4 billion for this year—directly out of the funds appropriated to its

4. In most cases, military retirees and their dependents become eligible for Medicare when the retirees reach age 65. Therefore, the terms "Medicare-eligible beneficiaries" and "beneficiaries over age 65" are used interchangeably.

5. The new benefits apply to Medicare-eligible military retirees and dependents who are enrolled in Medicare Part B. Under the new provisions, those beneficiaries receive both Tricare and Medicare benefits.

Defense Health Care Program. For 2003, however, the Defense Authorization Act for Fiscal Year 2001 directs that the payments for the new health care benefits be made from a military retiree medical account, rather than DoD's annual budget. Under the new system, DoD will pay an accrual charge into the fund each year for the future health care benefits that are earned in that year. An independent board of actuaries will set the charges for each year so that, when invested in Treasury securities, DoD's payments will fully fund expected future benefits. DoD will not, however, be responsible for funding the cost of benefits attributable to military service before 2003. Those costs, which include the costs of medical benefits for cohorts of current retirees, become an unfunded liability of the fund. The Treasury will make payments into the fund to cover that liability for past service.

Accrual budgeting for the cost of deferred compensation is not new. Since 1985, DoD has budgeted for the cost of military pensions using an accrual system. One advantage of accrual budgeting is that it can provide more accurate information about the value of the resources devoted to national security in each year. Under an accrual budget, DoD is charged for the future benefits payable to those people who are currently providing military service. By contrast, with a cash system, the current year's defense budget reflects the cost of pensions or health care benefits provided now to retirees who ceased contributing to national defense years earlier. Another benefit of accrual budgeting is that it can provide better information for personnel decisions. Under a cash system, DoD decisionmakers may be more likely to make decisions about the size and composition of the force with little regard for the implications for future pension or medical costs for retirees. Under an accrual system, the cost of those future benefits is reflected in DoD's current budget through accrual charges, potentially giving the department a better picture of the full cost of military personnel.

In addition to its potential to provide better information and incentives, accrual budgeting could influence the allocation of resources to retirees and to DoD. At least one association of military retirees supported the use of accrual budgeting because it believed that that approach would help protect retirees' medical benefits from the annual competition for appropriated funds. Payments for those benefits made from the accrual funds are direct (entitlement) spending and are not subject to annual appropriations. And many observers within DoD initially believed that shifting the new benefits from cash funding in 2002 to accrual funding in 2003 would—if there was no change in DoD's total budget—provide the department with windfall savings. They expected that the accrual charges for today's relatively small military would be less than the cost of providing benefits to the large number of current retirees. That expectation, however, appears to have been incorrect. The board of actuaries assumed that inflation in medical costs would continue at a relatively high rate in the future. On the basis of that assumption, DoD estimates that the accrual charge for retirees' medical benefits will be $8.1 billion in 2003—nearly twice what it would have cost the department to continue to fund those benefits that year on a cash basis.

SETTING ACCRUAL CHARGES TO PROVIDE GOOD INCENTIVES

The extent to which accrual budgeting will provide clearer information and better incentives for DoD to use resources cost-effectively depends, in large part, on how it is implemented. A review of the accrual system that DoD now uses to budget for military retirement reveals two weaknesses. One is that the charges DoD pays on behalf of different types of military personnel do not reflect the expected future costs of their retirement benefits.[6] For simplicity, the charges reflect only the most basic distinction. The other weakness is that gains or losses to the accrual fund that result from legislated changes in the retirement system or from DoD's policy decisions are currently borne by the Treasury, rather than reflected in DoD's budget. That arrangement is a concern because the incentive to make cost-effective decisions may be weakened when decisionmakers do not bear the costs of their decisions in their own budgets.

In many respects, the accrual system planned for retirees' medical benefits mirrors the existing system for retirement pay and thus could be subject to similar criticisms. In addition, the incentives provided by accrual charges for retirees' medical benefits could be further weakened if they are paid from the budget of the Defense Health Care Program, rather than from the budgets of the individual military services, where the costs of most other personnel decisions are borne.

Making Accrual Charges Reflect the Costs of Different Types of Personnel

Under current law, DoD's medical accrual payments will be uniform for all service personnel. The only distinction in the payments will be between those for full-time service members and those for part-time reservists. Because part-time service members are much less likely to reach retirement, the accrual charges for them will be only about one-fifth as high as the charges for full-time personnel. The board of actuaries will set annual per capita charges for both groups so that the contributions, together with the interest, will fund the expected future medical benefits.

The use of only two per capita charges—one for full-time service members and another for part-time service members—simplifies the actuaries' calculations. However, an accrual system with per capita charges that varied on the basis of other factors, such as an individual's branch of service and status as an officer or enlisted member, could more accurately capture the relative costs of different types of personnel. Active-duty Air Force officers, for example, are about four times more likely to qualify for retirement benefits than are enlisted Marines. As a result, the

6. See, for example, William M. Hix and William W. Taylor, *A Policymaker's Guide to Accrual Funding of Military Retirement* (RAND, 1997).

expected future medical costs in retirement associated with a year of service by an Air Force officer are several times greater than those associated with a year of service by an enlisted Marine. The current accrual system, which fails to take that difference into account, distorts the relative costs of different types of personnel.

Allocating Actuarial Gains and Losses to DoD

Under an accrual system, the accrual charges depend on projections of future costs and interest on the fund's balances. If those projections prove to be accurate, then the fund's receipts, together with its interest earnings, will cover the costs of future benefits. If the projections are not accurate, the fund has gains and losses. A net gain means that the contributions, and interest on those contributions, are expected to exceed the associated future benefits. A net loss means that the contributions and interest are not sufficient to fund the expected benefits. Gains and losses can arise either because of factors outside the control of DoD and the Congress (for example, if the actuaries' assumptions about future interest rates prove inaccurate) or because of factors within their control (namely, deliberate changes in legislation or policies).

Under the accrual system planned for retirees' medical benefits, DoD would not be credited for any gains and would not be charged for any losses regardless of the reason for those gains or losses. Instead, all of the gains and losses would be applied to, respectively, decrease or increase the contributions made by the Treasury, which is responsible for paying off the unfunded liabilities for benefits earned before 2003. That arrangement is consistent with the treatment of gains and losses under the accrual system for military retirement pay, a system that has been in use since 1985.

The Treasury amortizes gains and losses that arise from unexpected discrepancies between projected and actual interest rates, mortality rates, and other actuarial factors over which DoD and Congressional decisionmakers have little control. One advantage of insulating DoD from those gains and losses is that it avoids charging the department too much or too little today just because it inadvertently paid an incorrect amount in the past. Suppose, for example, that the new accrual fund for retirees' medical benefits experienced large net losses in its first years because of unexpectedly rapid inflation in health care costs in the economy as a whole but that those losses ceased once the actuaries modified their initial assumptions. Requiring DoD to subsequently amortize a portion of those losses would generally make accrual charges less accurate indicators of the costs of the medical benefits being earned by service members.[7]

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7. Some observers of the accrual system for military retirement pay have argued that the actuaries' estimates are inherently conservative, causing DoD to persistently pay more than is necessary to fund the system. If that was the case, a system in which DoD amortized past gains might sometimes provide a better signal of true costs because the gains from past years would offset some of the

Insulating DoD's budget from gains and losses that result from changes in legislation or the department's policies can reduce the incentive that the decision-makers who are responsible for DoD's spending have to control costs for the government as a whole. Rather than model the accrual system for medical benefits on the military retirement system—in which the Treasury bears all gains and losses—it may be appropriate to follow the example set by federal credit programs. Under the Credit Reform Act of 1990, the Treasury bears the savings or costs associated with unavoidable errors in financial projections. If, however, the costs of credit programs change because the terms of existing loans are modified, the agency that is responsible bears the expense. If DoD's health care programs for retirees followed that precedent, the Treasury would not amortize gains and losses that arose from legislated changes or DoD's policy changes. Instead, DoD would bear those costs in its budget in the year in which the changes became effective.

The military retirement system provides examples of how decisions could be affected by having the Treasury bear gains and losses that result from legislative changes or deliberate policy decisions. During the military drawdown that followed the Cold War, for example, DoD reduced the size of the active-duty force through various management tools. In making its personnel decisions, DoD took into account the savings in payroll and in recruiting and training, as well as the added costs of separation payments and incentives. However, the department did not take into account an estimated $18 billion in gains to the accrual fund because those gains were to be amortized by the Treasury in its payments to the fund and not credited to DoD. Had they been credited to DoD, the department might have chosen to retain fewer service members until their retirement.

In another instance, in 1999, legislation changed the formula used to calculate retirement pay for service members who entered active duty after 1986 to bring their retirement pay up to the same level as that for members who entered before then. Because DoD's payments into the accrual fund since 1986 were made under the assumption that entering cohorts were going to receive the more modest retirement package, increasing the benefits resulted in an estimated loss of about $4.5 billion in the accrual fund. Under the system in place (which will also apply to retirees' medical benefits), the Treasury is responsible for such unfunded liabilities. DoD's budget faced only the accrual charges, which CBO estimated at about $680 million for the first year. If credit reform practices had applied, DoD would have faced—in addition to the increase in accrual charges that it did see—a one-time charge of $4.5 billion when the new retirement system took effect. And if credit reform practices were applied to an accrual system for retirees' medical benefits, DoD would face similar one-time charges for actuarial gains and losses resulting from legislation or policy changes affecting the costs of those benefits.

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overcharges for the current year.

Paying Retirees' Medical Costs from the Military Pay Accounts

Current law requires DoD to make its annual payments to the accrual fund out of funds appropriated to the Defense Health Care Program, which is not part of the individual military services' budgets. One advantage of that approach is that it keeps the costs of retirees' medical benefits together with most of DoD's other health care costs. But a disadvantage is that it fails to link the costs of retirees' health care to the other costs of military compensation. The new accrual charges might be more effective in providing departmental decisionmakers with information about the full cost of military personnel and with incentives to use them efficiently if the individual services had to pay that cost out of their own appropriations for military compensation.

EXTENDING ACCRUAL BUDGETING TO ALL RETIREES' MEDICAL COSTS

Under the National Defense Authorization Act for Fiscal Year 2001, two important categories of medical benefits for retirees were not covered by accrual budgeting. One was the care provided in DoD's own treatment facilities to Medicare-eligible retirees, and the other was the care—whether purchased or provided in DoD's facilities—offered to military retirees who are not eligible for Medicare. Authority to extend accrual budgeting to the in-house care provided to Medicare-eligible retirees was provided in the National Defense Authorization Act for Fiscal Year 2002, and DoD is now developing the procedures necessary to incorporate the costs of that care in its accrual system. Unless existing law is modified, however, none of the medical care provided to military retirees who are not eligible for Medicare will be covered by the accrual system. DoD will instead continue to pay those costs on a cash basis, using each year's annual appropriation to cover the benefits provided that year. The advantages and disadvantages of extending accrual budgeting to these two categories of health care depend on how the system would be implemented.

Extending Accrual Budgeting to Cover the Treatment in DoD's Facilities

In recent years, DoD has estimated that its own treatment facilities have provided less than one-fourth of the health care used by Medicare-eligible retirees. Despite the size of that fraction, annual costs to the department reach about $1.2 billion. DoD is expected to issue new regulations that would extend accrual budgeting to cover those costs.

Depending on its implementation, that step could have serious implications for the efficiency of DoD's facilities. Suppose, for example, that the accrual fund reimbursed DoD for whatever the department spent on retirees and that the fund's losses were not charged back to the department's budget. In that case, DoD would

have little incentive to control the costs of treating those patients. In addition, DoD would have an incentive to attribute as much as possible of its total cost for health care to the care of Medicare-eligible beneficiaries.

Those adverse incentives could be avoided if the payments made to DoD out of the accrual fund on behalf of the Medicare-eligible retirees each year were not tied directly to DoD's reported spending on those retirees but set independently of that spending. Under such a system, the accrual fund could pay DoD a predetermined amount for each beneficiary to cover both DoD's share of the costs for purchased care and the costs for any care provided in-house. Under that approach, DoD would have an incentive to control the costs for care in its facilities. If actual costs were less than the capitated payments (per beneficiary), DoD could keep the savings; if actual costs were greater, DoD would be responsible for paying the difference out of its own budget.

Even with such a system, however, DoD would not have an incentive to choose between in-house and purchased care on the basis of their relative costs to the federal government as a whole. As discussed earlier, DoD pays for the care that retirees receive in its facilities, and Medicare pays for most of care that eligible military retirees receive outside of DoD's facilities, with the department making copayments and paying deductibles as a secondary payer. As a result, regardless of whether DoD relies on accrual or cash budgeting, it generally faces much lower costs when Medicare-eligible retirees seek care outside of DoD's facilities—even in cases in which relying on DoD's facilities would be cheaper overall, perhaps because of excess capacity there.

If the purpose of an accrual system was to provide information and incentives that led to cost-effective decisions from the perspective of the federal government as a whole, that system would have to reflect the full cost of care for retirees, regardless of whether it was delivered in military facilities or nonmilitary ones. An arrangement that put the costs of purchased and in-house care on an equal footing would give DoD an incentive to provide the most cost-effective mix of care. For example, DoD could assume responsibility for all of the costs of both purchased care and in-house care, with no contribution from Medicare; alternatively, the department could receive payments from Medicare, as other health care providers do. An analysis of those different policy approaches is beyond the scope of this paper, however.

Extending Accrual Budgeting to Cover the Health Care for All Military Retirees

DoD's health care costs for military retirees (and their dependents) who are not yet eligible for Medicare remain on a cash basis even though the costs for Medicare-eligible beneficiaries are shifting to an accrual basis. The planned accrual system could provide more comprehensive information and incentives if it covered military

retirees who are under age 65 as well as those over 65. Again, the cost-effectiveness would depend on how the system was implemented.

If younger retirees were included under accrual budgeting, there would be important reasons to expand the system to cover both the costs of the care they received in DoD's facilities and the costs of their purchased care. If, however, only their purchased care was covered by the accrual system, DoD could move younger retirees to purchased care to reduce its need for appropriations (other than for the accrual charges). Over time, the actuaries would likely update the accrual charges to reflect the higher ratio of purchased care to DoD-provided care, but nonetheless, DoD would benefit from savings in the year in which the care was provided and might not be concerned about the potential for higher accrual charges in the future. DoD would thus have a short-term financial incentive to shift retirees into purchased care even if it was, from the perspective of the federal government as a whole, cheaper to rely on the department's facilities to provide that care.

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